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In The

Supreme Court of the United States

October Term, 1984

SEBASTIAN REBALDO, as Chairperson of the Board of Trustees of the UNITED OPTICAL WORKERS INSURANCE FUND,

Petitioner,

vs.

MARIO CUOMO, GOVERNOR OF THE STATE OF NEW YORK; and DAVID AXELROD, COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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QUESTION PRESENTED

Whether a state statute that prohibits the continuation or negotiation of discount rate agreements between self-insured employee benefit plans and hospitals, while mandating discount rates for state regulated not-for-profit health insurance corporations, "relates to" an employee benefit plan within the meaning of Section 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1144(a) and is therefore pre-empted by that Act.*

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* The caption of the case in this Court contains the names of all parties in the United States Court of Appeals for the Second Circuit. Blue Cross and Blue Shield of Greater New York ("Blue Cross") and the Hospital Association of New York participated in the court below as *Amici Curiae* in support of respondents.

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OPINIONS BELOW

The November 26, 1984 opinion of the United States Court of Appeals for the Second Circuit is reported at 749 F.2d 133 and is reprinted at Appendix ("App".) 1-16 to this petition. The March 12, 1984 opinion of the United States District Court for the Southern District of New York is not officially reported and is reprinted at App. 17-43 to this petition.

JURISDICTION

The judgment of the United States Court of Appeals for the Second Circuit was entered on November 26, 1984. This Court has jurisdiction pursuant to 28 U.S.C. §1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Relevant portions of Section 514 of the Employee Retirement Income Security Act of 1974, as amended, ("ERISA"), 29 U.S.C. §1144 and Section 2807-a.6(b) of New York Public Health Law (McKinney Supp. 1984-1985), are reprinted at App. 49-52 to this petition.

STATEMENT OF THE CASE

This case involves the extent to which a State may, through regulation, influence the form and operation of employee benefit plans. The issues presented are related closely to those before the Court in *Metropolitan Life Insurance Company v. Commonwealth of Massachusetts*, No. 84-325, *argument scheduled*.

Petitioner is the Chairperson of the Board of Trustees of a small self-administered employee welfare benefit plan[1] ("the Fund") that provides health, hospitalization and other benefits to approximately 1500 employees and their dependents. The Fund's participant work for 180 contributing employers located in five states: New York, New Jersey, Connecticut, Massachusetts and Florida.[2]

The employee participants in the Fund receive modest salaries. Without the benefits provided by the Fund, these participants would be "medically indigent" because they could not afford to purchase health insurance from Blue Cross and other commercial insurers, yet they earn too much to qualify for federal medical assistance under Medicaid. But for the Fund, hospitals that provide care to this group would often be unable to collect their fees. By providing hospital coverage to groups otherwise medically indigent, the Fund serves an important public interest.

The Fund provides benefits to its participants and their dependents regardless of past medical experience or health risk.

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1. Section 3(1) of ERISA, 29 U.S.C. §1002(1), defines an "employee welfare benefit plan", in part, as one that is "established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical or hospital care or benefits." Section 3(3) of ERISA, 29 U.S.C. §1002(3), defines the terms "employee benefit plan" and "plan" to mean either an employee welfare benefit plan or an employee pension benefit plan. As used herein the terms "ERISA fund" and "plan" mean an employee welfare benefit plan.

2. The facts as set forth were contained in the complaint and papers submitted in the district court in support of a motion for a preliminary injunction. At the suggestion of the district court the parties and amicus curiae Blue Cross agreed to treat the motion as one for summary judgment on the issue of pre-emption under ERISA and further agreed that there were no material facts in dispute. Accordingly, for the purposes of this petition, the material facts as asserted by the Fund must be deemed uncontested.

It is the primary provider under Medicare for workers aged 65-69, who are entitled to the same benefits offered under the plan to younger workers. The Fund also provides benefits for pensioners and laid off employees. Benefits are provided to all participants without reference to their income or the rate at which each member's employer contributes.

The Fund's primary source of funding consists of the contributions made by employers pursuant to collective bargaining agreements with United Optical Workers Local 408, IUE, AFL-CIO ("Union"). Those agreements fix the rate of contributions for a period of three years, the duration of the contracts. Because of depressed economic conditions in the optical industry during the past few years, the Union experienced great difficulty in negotiating increases in Fund contributions. At the same time, the cost of providing benefits to the participants increased dramatically. As a result, the Fund suffered serious losses in its assets since 1980. Among the major escalating costs faced by the Fund prior to 1983, were the charges to the Fund for Blue Cross hospitalization coverage.

In 1982, in order to reduce losses and enable the Fund to keep the hospitalization benefits for its members intact, the trustees of the Fund decided to end its relationship with Blue Cross effective January 1, 1983. Instead of insuring with Blue Cross, the Fund became self-insured and continued to provide the same hospital benefits previously provided under contracts with Blue Cross. ERISA leaves the decision of whether to insure or self-insure a welfare plan to the discretion of the trustees. Section 3(1) of ERISA states that a welfare plan may be maintained "through the purchase of insurance or otherwise". Accordingly, so long as the trustees are acting "for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan", Section 404 of ERISA, 29 U.S.C. §1104, the decision about how to structure the plan is theirs to make. Here, after careful review of the

alternatives, the trustees concluded they could best provide benefits and conserve fund assets by turning to self-insurance.

Self-insurance represented a major step toward defraying expenses and conserving assets, primarily because the Fund was able to negotiate directly with hospitals for hospital charges. Through its agent, the Fund obtained agreements with over 100 area hospitals, calling for charges at rates 5% above the rate paid by Blue Cross. Coupled with more effective claim and billing practice review, increased administrative efficiency and the cash flow benefit derived from paying claims rather than insurance premiums (which require a 3 to 4 month reserve account) during the first 8 months of 1983 under self-insurance, the Fund reaped substantial savings. The Fund's actuary projected that for the first 12 months under self-insurance the Fund would save approximately $120,000, without reduction of benefits.

The State Statute at Issue

New York Public Health Law Section 2807-a.6(b) went into effect on January 1, 1984. As of that date, all discount agreements between self-insured ERISA funds and hospitals governing in-patient hospital charges were prohibited. In place of the outlawed agreements, the statute compels ERISA funds to reimburse hospitals for services rendered to their members at mandatory rates set at 12-15% above those charged to subscribers of not-for-profit health insurance companies incorporated under Article 9-C of the New York Insurance Law, of which Blue Cross is by far the largest. Hospitals are directed to grant the mandatory discounts to Blue Cross and are prohibited from accepting less than the statutory maximum from employee benefit plans. A statutory exception was created for employee benefit plans with discount contracts in effect on May 1, 1982, permitting them to continue. Thus, not only did the legislature consider ERISA plans when it enacted the statute, the State actually created separate

classes of ERISA plans by carving out an exemption for plans with contracts in existence before May, 1982.

The opinion below implies that a finding of pre-emption would endanger a state interest. While such considerations are irrelevant under ERISA, the fact is that pre-emption of the provision of the statute relating to ERISA plans would have no discernible impact on the goal of containing hospital costs.[3]

The Proceedings in the District Court

Although pre-emption would have no impact on the State's cost containment goals, the impact of the statute on self-insured employee benefit plans would be devastating. For petitioner, who had recently left Blue Cross and turned to self-insurance as a means of minimizing expenses and preserving benefits in the face of serious financial problems, the loss of its discount agreements with hospitals spelled financial disaster. Without the ability to continue to pay hospitals for services provided to Fund members at rates competitive with those provided to subscribers of Blue Cross, the Fund would have to reduce benefits, forego self-insurance and return to Blue Cross.

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3. The Deputy Director of the Office of Health Systems Management conceded that at the time Section 2807-a.6(b) was enacted, the State was unaware of the "nature and extent of [self-insured ERISA fund] discount charges agreements." Joint Appendix ("J.A.") filed in the Second Circuit at 391. Thus, it was also unaware of the number of agreements preserved by the provisions exempting discount agreements entered into prior to May 1, 1982. By the State's own admission, the exemption for plans with contracts in effect in 1982 could have preserved 99.9% of ERISA fund contracts and outlawed only .1% of such contracts. In fact, in opposition to the State's motion for a stay pending appeal, the Fund disclosed that the number of self-insured ERISA funds whose contracts were abrogated by this statute accounted for under 1% of total hospital in-patient revenues. Hence, pre-emption of the offending provision could make no appreciable difference on the statute's effectiveness. Rather, as shown in

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Because the state statute posed a serious threat to the structure, operation and plan of benefits provided by the Fund, it commenced this suit for injunctive and declaratory relief, alleging pre-emption under Section 514(a) of ERISA, 29 U.S.C. §1144(a). That section provides in relevant part:

> ". . . the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title . . . ."

The Fund moved for a preliminary injunction in the district court.[4] That motion was converted with the consent of the parties to a motion for summary judgment on the question of pre-emption under ERISA. In opposition, the State and amicus Blue Cross conceded that the statute regulated and related to ERISA funds, but argued that it was saved from pre-emption by the exception

(Cont'd)

the district court, its inclusion in the statute was the apparent result of a successful lobbying effort by Blue Cross to put an end to self-insured and self-administered employee benefit plans in New York State. The State itself conceded that one of the goals of the legislation was: "Keeping Blue Cross competitive in the marketplace." (Appellant's Memorandum in Support of Motion for a Stay Pending Appeal filed in the Second Circuit at p. 17). In seeking a stay from the district court judgment the State also admitted that one of the perceived "danger[s]" of that judgment was: "the possibility that the March 30 judgment will encourage large numbers of currently non self-insured ERISA funds to become self-insured." (J.A. 391).

4. The Fund also claimed that the statute violates the antitrust laws, the commerce, contracts and supremacy clauses of the United States Constitution and the Equal Protection Clause of the Fourteenth Amendment. The basis for federal jurisdiction in the district court was Section 502 of ERISA, 29 U.S.C. §1132; 28 U.S.C. §1331(a); 28 U.S.C. §1337 and 15 U.S.C. §15.

for laws regulating insurance (Section 514(b)(2)) (App. 50), and by Section 514(d) (App. 51), which preserves federal laws from ERISA pre-emption.

Neither the State nor Blue Cross ever suggested in the district court that the state statute does not "relate to" ERISA funds. As the district court found:

> "Neither defendants nor *amicus* argues that §2807-a.6(b) does not relate to ERISA plans, and such an argument would not prevail. Section 2807-a.6(b) adversely affects the administration of such plans in at least two ways. It is obvious that if the Fund is required to pay the higher reimbursement rates set for charge payors, it will not be able to provide the same breadth of coverage for its beneficiaries. Its other alternative is to return to the previous arrangement of purchasing insurance through Blue Cross, but the Fund asserts that its experience has shown this arrangement to still be more expensive than the present system, and that some reduction in benefits would still be necessary to cover increased costs.
>
> In addition, by imposing a local condition on the administration of covered funds, §2807-a.6(b) runs afoul of ERISA's goal of facilitating the operation of uniform multi-state plans. In order to best conserve assets, the Fund might well find it practical to operate separate plans in different states; it might find that it could provide benefits most efficiently by insuring through Blue Cross in New York and by self-insuring in states without similar restrictions. This would result in higher administrative costs, and, as the Supreme Court noted in *Shaw*, would eventually necessitate a decrease in benefits.

> It should be noted, as well, that §2807-a.6(b)'s impact on ERISA plans is not incidental; it is apparent from the express exclusion of discount contracts entered into by 'self insured and self-administered groups' before May 1, 1982 that the legislature considered ERISA plans and fully intended to curtail their ability to negotiate or receive discounts after January 1, 1984. This conclusion is further supported by direct references to 'self-insured groups [that] have negotiated payment rates with individual hospitals' in a report by the statutorily-created Council on Health Care Financing, which was charged with devising a plan for financing hospital inpatient care, and also by statements attributed to Edwin Werner, the President of Blue Cross and a member of the Council on Health Care Financing.
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> * * *
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> I am convinced, based upon the foregoing, that §2807 a.6(b) 'pertains to' and 'refers to' ERISA funds, and that it has a direct 'bearing on' and 'connection with them.' " (App. 25-27).

The Proceedings and Opinion Below

On appeal, the State for the first time claimed that the statute did not "relate to" ERISA funds. Although not argued at the district court level, the Court of Appeals determined to entertain the argument noting the "broad legal ramifications" of the decision in this case (App. 8).

In urging affirmance of the district court's opinion, the Fund pointed out that the obvious and conceded purpose of the state

law to regulate employee benefit plans was dispositive.[5] However, the Fund also discussed at length the *impact* of the statute as further evidence that it "relates to" employee benefit plans. The Fund showed that:

> 1. The state law impermissably interfered with the right of employee benefit plans to be structured and operate through self-insurance;
>
> 2. The statute imposed an onerous economic burden on self-insured employee benefit plans that would force the Fund to reduce benefits; and
>
> 3. The statute undermined the Fund's ability to maintain uniform interstate administration.

Acting under the erroneous premise that it should rule against pre-emption unless an opposite result was "unavoidable" (App. 11), the court below held that the state law did not "relate to" ERISA funds. It reached its conclusion in reliance on footnote 21 of this Court's opinion in *Shaw v. Delta Air Lines*, 462 U.S. ____, ____ n.21, 103 S.Ct. 2890, 2901 n.21 (1983), regarding state actions that affect employee benefit plans "in too tenuous, remote or peripheral a manner to warrant a finding that the law 'relates to' the plan".

The opinion made no mention of petitioner's claims and the district court's findings with respect to the clear purpose and effect of the state law to regulate and curtail the rights and activities of employee benefit plans and discourage self-insurance. Although the court held (App. 9) that the phrase "relate to" under Section

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5. The Fund noted other legislative history in addition to that which was cited by the district court in which the State's purpose to regulate ERISA plans was disclosed. (See J.A. 162 No. 11, 141 No. 2).

514(a) was limited to actions which regulate the "terms and conditions" of an employee benefit plan (ERISA Section 514(c)(2)),[6] it failed to consider whether the statute regulated any "terms and conditions" of employee benefit plans.[7]

The Second Circuit predicated its decision on its conclusion that contracts or arrangements for the provision of hospital care are merely incidental aspects of the plan's "cost of doing business", no different from "rent control laws" or "bridge and tunnel tolls" (App. 12).[8] But, the sole function and purpose an employee welfare benefit plan is to provide hospital care or benefits. 29 U.S.C. §1002(1). Contracts fixing the terms governing the cost of those benefits are not remote or peripheral but rather

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6. 29 U.S.C. §1144(c)(2). That section defines the term "State" following the definition of "State Law" as follows: "The term 'state' includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter."

7. The Fund pointed out that *Shaw* interpreted the phrase "relate to" without any reference to the phrase "terms and conditions" contained in Section 514(c)(2) presumably because there, as here, it was not disputed that the law in question was the enactment of a "State". The Fund also cited H.R. Rep. No. 1785, 94th Cong. 2d. Sess. 47-48 (1977) (a report cited by this Court in *Shaw*, 103 S.Ct. at 2901 n.20), for the view that the phrase "terms and conditions" was not intended "to limit the preemptive effect of Section 514(a)." That report concluded that "the phrase 'terms and conditions' . . . has a very broad scope . . ." and that "any activity by a state or political subdivision thereof, which relates to employee benefit plans, *qua* benefit plans, is preempted by Section 514(a)."

8. If a state rent control law outlawed all leases entered into between employee benefit plans and landlords and directed that plans pay rent at rates 15% higher than that charged to state regulated health insurance companies, the law would "relate to" ERISA funds within the meaning of Section 514(a). Like the statute here, any regulation directed specifically at ERISA plans would *per se* "relate to" such plans.

have a direct and substantial impact on the basic operation and structure of such plans. A statute abrogating the Fund's contracts and mandating that employee benefit plans pay the maximum hospital charges permitted, is hardly analogous to the "tangential" laws cited by the court below, i.e., those incidentally affecting some individual employees, garnishment of pension benefits to collect child support, etc.

This statute is also quite different from the human rights law considered by the Ninth Circuit in *Lane v. Goren* (No. 83-6496 Sept. 27, 1984), decided after oral argument in the court below and cited twice in the court's opinion (App. 10, 11-12). The ban on racial discrimination in that statute did not in any way purport to regulate employee benefit plans *qua* employee benefit plans. Nor was that the intent of the California legislature. Moreover, the prohibition against a fund's treatment of its employees in a racially discriminatory manner affected no essential purpose or function of the fund.

In ruling that the instant statute survived ERISA pre-emption, the Second Circuit misconstrued the decisions of this Court, employed an analysis of pre-emption inappropriate under ERISA and opened the floodgates to precisely the kind of patchwork and conflicting state legislative enactments that ERISA's broad pre-emption provision was designed to prevent.

REASONS FOR GRANTING THE WRIT

I.

This case involves important questions of federal law presently under consideration by this Court.

This case involves important federal questions affecting the structure and operation of employee benefit plans that parallel closely those the Court has undertaken to consider in *Metropolitan*

Life Insurance Company v. Commonwealth of Massachusetts, No. 84-325. In both cases, state statutes designed with employee benefit plans in mind, have survived pre-emption challenges, by an expansive interpretation of the exceptions to pre-emption. In both cases the courts have employed an analysis that is inappropriate in view of the explicit pre-emption provision contained in ERISA, its legislative history, and this Court's determination that Congress intended to achieve the broadest possible ouster of state action in the employee benefit plan area.

Considered together, these cases highlight how state action can erode ERISA's goals of promoting the growth, financial soundness and opportunity for uniform multistate administration of employee benefit funds.[9] The statute before the Court in *Metropolitan* purports to confine its regulatory impact to those funds purchasing insurance. The lower court there eliminated the requirement that self-insured ERISA funds provide certain benefits required of insurance companies. Therefore, to avoid the restrictions imposed by the statute, employee benefit plans in Massachusetts must self-insure. In contrast, the statute at issue here operates as a dis-incentive to self-insurance by employee benefit plans. Although the statute does not directly forbid self-insurance or compel plans to insure through Blue Cross, that is its clear effect.[10]

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9. In fact, the New York statute's requirement that Funds pay the maximum rates chargeable by hospitals will have a more devastating impact on ERISA funds than could the Massachusetts mandated benefit statute. The New York statute requires this Fund to pay at least 10% more for all hospital services than it is obliged to pay under its discount contracts prohibited by the state law. The increased expense for the mental health coverage at issue in *Metropolitan* is slight by comparison.

10. The impact of the conflicting state pressures on this Fund are startling. This Fund has employees and benefit programs in both New York and Massachusetts. It is pressured to self-insure in Massachusetts and to abandon

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Because of the similarity of issues raised by the two cases, the Court's decision in *Metropolitan* will affect the judgment in this case. If this Court adopts the analysis of pre-emption advocated by the appellants in *Metropolitan*,[11] it will rule that laws that have the effect of regulating ERISA plans must be pre-empted regardless of whether they also purport to regulate insurance. In that event, the Second Circuit will have decided a federal question in a way in conflict with a decision of this Court. In any event, consideration of this case along with *Metropolitan* will enable the Court to provide needed guidelines for the lower courts in applying the pre-emption provision of ERISA.

Moreover, this case presents important federal questions that go beyond the issues in *Metropolitan*. The decision below permits a state with an acknowledged purpose and intention to regulate employee benefit plans, to do so. It permits a state to restrain the growth and financial soundness of self-insured employee benefit plans because of some perceived state benefit in enhancing the competitive status of Blue Cross. However, Congress made clear that the decision of whether to fund and administer a plan

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self-insurance in New York. Adapting to the conflicting requirements of the two statutes becomes virtually impossible under a uniform system of administration. Even without the contradictory pressures of the Massachusetts law, maintenance of self-insurance in the other states obviously will be more expensive administratively if the Fund must forego self-insurance in New York. A reversion to Blue Cross in order to take advantage of its statutory discount, would require the Fund to relinquish control over the administration of claims in New York. Premiums the Fund would be charged by Blue Cross would include payment to the insurance company to administer those claims. Retention of Fund personnel solely to administer the self-insured claims in other states would obviously be less cost-effective and, depending on the ratio of such claims to New York claims, might require abandonment of self-insurance on a multi-state basis altogether.

11. Brief for appellant in *Metropolitan*, p. 34, 35.

through insurance or self-insurance was a matter left to the discretion of the fiduciaries administering the plans. The trustees of the Fund are charged under ERISA to act solely in the best interests of the participants and beneficiaries and for the "exclusive purpose of providing benefits" and "defraying reasonable expenses, of administering the plan." ERISA Section 404(a)(1)(A), 29 U.S.C. §1104 (a)(1)(A). They are obliged therefore to provide the maximum benefits to the participants at the least possible expense. The New York statute interferes directly with the duties of the trustees. In so doing it effectively forecloses a method of plan operation expressly permitted by Congress.

The Fund does not dispute that rising hospital costs are a matter of national concern.[12] Indeed, the Fund has been in the forefront of efforts to control hospital costs by undertaking stringent billing practice and claim review following its conversion to self-insurance. The opinion below was, in effect, based on the court's view of the importance of the state law. The court implicitly balanced the goals of the State against the Fund's rights under ERISA. Yet, however attractive state efforts to control hospital costs may appear, absent amendment by Congress, regulation under the guise of cost containment in the health care field should not be permitted to thwart the clear mandate of ERISA to pre-empt state laws relating to employee benefit plans.

The ruling below was inappropriate and unless reviewed will serve as authority for further significant erosion of pre-emption.

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12. Obviously the Fund does not contend that all state hospital cost containment efforts are pre-empted. Concededly, there are many state laws controlling hospital costs that do not run afoul of the pre-emption provision.

II.

The decision below is in conflict with decisions of this Court and with the decisions of other federal courts of appeals.

There is no room after *Shaw* for an analysis which precludes a finding of preemption under ERISA unless a contrary conclusion is "unavoidable." In fact, the opposite is the case. This Court held that "Congress used the words 'relate to' in §514(a) in their broad sense", *Shaw* at 2900, "creating only very limited exceptions to pre-emption." *Shaw* at 2903. Hence, it was the duty of the court below to apply the term expansively rather than in the strained and narrow manner that it did.

Rulings calling for pre-emption of state law in the health care field prevailed even prior to *Shaw*. Thus this Court affirmed summarily the Ninth Circuit's holding in *Standard Oil of California v. Agsulud*, 633 F.2d 760, 766 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981), that the Hawaii Pre-Paid Health Care Act was pre-empted by ERISA. The Ninth Circuit explicitly took "a broad view of the pre-emption of federal law over state law in the health insurance field . . . ." The court in *Agsulud* specifically endorsed Judge Renfrew's pertinent comments that: "ERISA shall supersede any and all state laws and that does not mean 'some but not all state laws.' " 633 F. 2d at 765, *citing* 442 F. Supp. 655 at 707 (N.D. Cal. 1977). Judge Renfrew also had remarked: "[t]o hold that a state health insurance law does not regulate directly or indirectly the terms and conditions of employee benefit plans would distort the meaning of those words beyond recognition." *Id.* Similarly, the opinion in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981), noted that although the workers compensation awards there were "obviously . . . subject to the State's police power," even indirect interference with an employee benefit plan could not escape pre-emption:

> "It is of no moment that New Jersey intrudes indirectly through a workers compensation law, rather than directly through a statute called 'pension regulation.' ERISA makes clear that even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern . . . ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision." 451 U.S. at 525.

The decision below is also in conflict with the Ninth Circuit's decision in *Hewlett-Packard Company v. Barnes*, 571 F. 2d 502 (9th Cir. 1978), *cert. denied*, 429 U.S. 831 (1979). There, the court ruled that an analogous California statute regulating health maintenance organizations[13] was pre-empted to the extent it applied to employee benefit plans. The Ninth Circuit again adopted (571 F. 2d at 504) the reasoning of Judge Renfrew who held:

> "Effective since July 1, 1976, Knox-Keene governs the delivery of health care services to California residents who participate in health care service plans. In enacting Knox Keene, the California legislature intended to promote the delivery of low cost, quality health care through financially sound plans to participants well informed of the benefits of various available plans.
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> Although defendant finds the phrase 'relate to' 'vague and ambiguous,' the Court doubts that

13. The statute here grants mandatory discounts to health maintenance organizations as well.

> Congress could have chosen any more precise language to express its intent to preempt a state statute such as Knox-Keene insofar as it seeks to regulate ERISA-covered employee benefit plans such as those maintained by plaintiffs." 425 F. Supp. 1294, 1297 (N.D. Cal 1977). (Footnote omitted).

As this Court noted recently in *Brown v. Hotel and Restaurant Employees Local 54*, 104 S.Ct. 3179, 3185 (1984):

> "When federal pre-emption is invoked under the directive of the Supremacy Clause, it falls to this Court to examine the presumed intent of Congress. See *Fidelity Federal Savings & Loan Assn. v. De La Cuesta*, 458 U.S. 141, 152-153 (1982). Our task is quite simple if, in the federal enactment, Congress has explicitly mandated the pre-emption of state law, *see Shaw v. Delta Air Lines* . . ."

Having reviewed the analysis applied by the courts in Section 514 cases, one commentator stated:

> "The goal of an express pre-emption analysis... should be to prevent subtle or incremental state encroachment into a field that Congress has chosen expressly to reserve for federal law. Yet, courts have mistakenly applied pre-emption doctrines fashioned in implied pre-emption cases to section 514 cases, in which the issue is whether the federal law — by its express terms — pre-empts the state law in question. Once Congress has declared its express intent to pre-empt or to save a state law, it has largely obviated judicial inquiry into considerations other than those concerning the text

> of the pre-emption provision." Kilberg and Inman, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514* ("Kilberg") 62 Texas L.R. 1313, 1316 (1984).

Criticizing the same kind of analysis as that employed by the Second Circuit here, *Kilberg* continued:

> "The first approach, which calibrates the extent of ERISA pre-emption to reflect the importance of the relevant state law, contravenes Congress' unmistakable intent. Congress sought to pre-empt all state laws that relate to employee benefit plans except for those it exempted specifically. Neither marital property laws, nor antidiscrimination laws, nor any other state laws that courts have found to merit special scrutiny are on the statutory list. Once Congess has decided to disrupt the federal-state balance to a given degree, the courts have no legitimate basis for reweighting that balance. To focus on the traditional role of the state in a particular field or the importance of a given law to the state is to circumvent the analysis of whether the law in question relates to employee benefit plans within the meaning of Section 514(a)." 62 Texas L.R. at 1326 (Footnotes omitted).

The only *narrow* reading of ERISA pre-emption permitted under *Shaw* respects the scope of the *exceptions* to pre-emption, not the other way around. The opinion below permits the exceptions to pre-emption under ERISA to swallow the rule and distorts the meaning of Section 514(a) beyond recognition.

Even if the narrow standard employed below could somehow be reconciled with the cited opinions, the lower court's actual

treatment of the statute's relation to employee benefit plans was entirely inadequate. The Second Circuit implied that preemption is limited to those State laws requiring or prohibiting benefits (App. 11).[14] That is not the case. In *Agsalud,* the opposite argument was made by the State of Hawaii, namely, that ERISA pre-empts only state laws dealing with plan administration and exempts all laws dealing with benefits. This Court affirmed the opinion of the Ninth Circuit which noted: "There is, however, nothing in the statute to support such a distinction between the state laws relating to benefits as opposed to administration." 633 F. 2d 760 at 765.

In an analogous situation involving legal services plans, Senator Javits, one of the leading sponsors of ERISA, emphasized that pre-emption could not be avoided by indirect state action regulating form rather than content:

> "the State, directly or indirectly through the bar, is pre-empted from regulating the form and content of a legal service plan, for example, open versus closed panels, in the guise of disciplinary or ethical rules or proceedings." 120 Cong. Rec. 29,948-49 (1974).

Similarly, "in the guise" of regulating hospital costs, the State may not affect the self-insured as against the insured "form" of an employee benefit plan.

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14. The statement below that the statute did not affect the structure, administration or type of benefits provided (App. 12) completely ignores the uncontested facts. As the matter of the statute's "relation to" ERISA funds was never litigated in the district court, the Second Circuit was bound to accept the Fund's contentions as true. It was certainly not free to ignore the record or make implied factual findings contrary to the record on an issue never raised in the trial court.

Equally unacceptable under *Shaw* was the Second Circuit's reliance on the purported "general" character of the state law (App. 12 and n.2). *Shaw* specifically emphasized that the generality of the law was irrelevant under Section 514(a): "It would have been unnecessary to exempt generally applicable state criminal statutes from pre-emption under §514(b), for example, if §514(a) applied only to state laws dealing specifically with ERISA plans." 103 S.Ct. at 2900.[15]

The Second Circuit concluded that the state law's effect on employee benefit plans was peripheral, apparently because it found that the statute's economic impact was indirect (App. 12). However, the equation of "peripheral" with "indirect" runs afoul of the express language of ERISA and ignores a wealth of judicial authority that has interpreted it.[16]

It has long been recognized that the power to impose costs is the equivalent of the "power to destroy [and] that the power to destroy may defeat and render useless the power to create."

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15. *See Pervel Industries Inc. v. Connecticut Commission on Human Rights and Opportunities*, 468 F. Supp. 490, 492 (D.Conn. 1978), *aff'd mem.*, 603 F.2d 214 (2nd Cir. 1979), *cert. denied*, 443 U.S. 1031 (1980); *Baker v. Caravan Moving Corporation*, 561 F. Supp. 337 (N.D. Ill. 1983); *National Carriers' Conference Committee v. Heffernan*, 454 F. Supp. 914 (D. Conn. 1978).

16. In noting that some state actions may affect employee benefit plans so peripherally that they do not relate to them, the *Shaw* opinion cited *American Telephone Company v. Merry*, 592 F. 2d 118 (2nd Cir. 1979), as illustrative. That case premised its holding on the theory enunciated in *Stone v. Stone*, 450 F. Supp. 919, 924 (N.D.Cal. 1978), *aff'd*, 632 F.2d 740 (9th Cir. 1980), *cert. denied sub nom., Seafarers Int'l Union v. Stone*, 453 U.S. 922 (1981), that ERISA should not be construed as infringing *sub silentio* "the power to make rules to establish, protect and strengthen family life . . .", and a similar statement by Judge Weinfeld in *Cartledge v. Miller*, 457 F. Supp. 1146, 1154 (S.D.N.Y. 1978), finding that no inference should be made "that Congress meant to preclude the *ancient* family law right of maintenance and support and the issuance of process to enforce that right."

(Cont'd)

M'Culloch v. Maryland, 14 U.S. (4 Wheat.) 431 (1819). Surely, Congress did not intend that through a law regulating hospital reimbursement methods States could place an economic stranglehold on the very plans they were forbidden to regulate.

Merely because a state law has an indirect economic impact on an employee benefit fund does not render it peripheral. Where as here, the State is regulating the purchase of health care, the very business of the Fund, it cannot be said that such regulation is peripheral and therefore does not "relate to any employee benefit plan".

This and other courts have been careful to scrutinize state action, however categorized, which impacts on employee benefit plans, to prevent by indirection as well as by direct action, erosion of the pre-emption mandated by Congress. *Alessi* involved a state law prohibiting certain offsets in pension benefits. This Court's opinion reviewed carefully Congress' goal of containing costs of employee plans and quoted extensively from reports expressing concern over practices that would increase the costs of providing pension benefits. 451 U.S. 514-516. Likewise, *Shaw* acknowledged that pre-emption of a state law requiring the provision of pregnancy benefits, furthered Congress' desire to prohibit state laws that would increase plan expenses. 103 S.Ct. 2904 n.25. Closely analagous to the type of economic impact of the statute here is that involved in the state tax law considered in *National*

(Cont'd)

The distinctions between this case and the marital support cases are self-evident. A marital support order affects a single individual and has no impact on a plan's ability to fulfill its basic statutory purpose. The legislation at hand deals with the lifeblood of the plan and affects the purpose for which it exists.

Similar attempts by states to analogize to the *Merry* line of cases have been rejected. *Stone & Webster, supra,* 690 F.2d 323 at 329; *Standard Oil Company of California v. Agsalud, supra,* 633 F.2d 760, 766 (9th Cir. 1980), *aff'd mem.,* 454 U.S. 801 (1981) and *Hewlett-Packard Company v. Barnes,* 571 F.2d 502 (9th Cir. 1978), *cert denied,* 439 U.S. 831 (1979).

Carriers' Conference Committee v. Heffernan, 454 F. Supp. 914 (D. Conn. 1978). That law required plans to pay a tax on benefits and at rates higher than those set for insurance companies. That court's rejection of the claimed exception for tax laws applies with equal force to this case:

> "The phrase 'any and all' plainly indicates an intention to reach every state statute that fits the description of 'relating to' an employee benefit plan. Just as plainly the tax imposed by §12-211c is such a statute. The statute is not merely a general taxing provision that catches employee benefit plans within its wide sweep. On the contrary, the tax is specifically directed at such plans exclusively, and is distinct from the tax applied to insurance company premiums. See Conn. Gen. stat. §12-202 (Supp. 1978). Clearly it 'relates to' ERISA covered plans."
>
> " . . .where Congress has not excluded even general tax statutes from pre-emption, a statute specifically directed at an ERISA-covered plan must certainly come within the pre-emption provision." 454 F.Supp. at 915, 916.
>
> "In the present action the challenged statute imposes a 2.75% annual tax on benefits paid by employee benefit plans. This contrasts with Connecticut's tax on the premiums received by insurance companies, which is only 2%. Conn. Gen. Stat. §12-202. *This tax structure may operate as an incentive to use traditional insurance, rather than ERISA-covered plans.* Although the impact of the tax discrepancy may be only nominal at present, its economic impact is not the measure of its significance. Rather, the discrepancy is

illustrative of the potential use of taxation as a means of regulation. Because of that potential, pre-empting state taxation of ERISA-covered plans is necessary to effectuate Congressional objectives." 454 F. Supp. at 918. (emphasis supplied).[17]

The fact is that Congress considered carefully the kind of state laws it desired to preserve from pre-emption and this statute falls within none of the exemptions.[18] There is simply no basis

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17. In creating, post *Agsulud*, a limited exception to pre-emption for the Hawaii Pre-Paid Health Care Act, Congress specifically directed that it *not* be construed to exempt from pre-emption "any state tax law relating to employee benefit plans . . ." ERISA Section 514(b)(5)(B)(i), 29 U.S.C. §1144(b)(5)(B)(i). *See also, Pervel, supra,* 468 F.Supp. at 493 (State law "can only add to the cost of administration and ultimately impose costs on plan beneficiaries."); *Stone & Webster Engineering Corp. v. Ilsley,* 690 F. 2d 323, 326 (2nd Cir. 1982), *aff'd, sub nom. Arcudi v. Stone and Webster Engineering Corporation,* _____ U.S. _____, 103 S.Ct. 3564 (1983); *Blue Cross and Blue Shield of Alabama v. Peacock's Apothecary,* 567 F. Supp. 1258 (N.D. Ala. 1983) (State law regulating discount pharmacy rate contracts pre-empted); *Dawson v. Whaland,* 529 F. Supp. 626, 632 (D.N.H. 1982) (New Hampshire statute, compliance with which represented only additional estimated $23,000 in administrative expenses to plaintiff funds held pre-empted); *General Split Corporation v. Mitchell,* 523 F. Supp. 427 (E.D. Wis. 1981) (Wisconsin's attempt to require employee benefit plans to participate in health insurance risk sharing plans (similar to the bad debt and charity pools established under the law in issue) which created administrative and other expenses for plan held pre-empted); *St. Paul Electrical Workers Welfare Fund v. Markman,* 490 F.Supp. 931 (D. Minn. 1980). Advisory Opinions from the Department of Labor finding that laws increasing plan expenses are pre-empted abound. *See* DOL Advisory Opinion No. 80-60A (Oct. 10, 1980) (California's Confidentiality of Medical Information Act pre-empted); DOL Advisory Opinion No. 81-70A (Illinois Law restricting the rate of interest which may be charged individuals in loan transactions pre-empted); DOL Advisory Opinion No. 79-40A (December 12, 1979) (State of California tax levies on plans for unpaid taxes or unpaid unemployment insurance contributions pre-empted).

18. If the State of New York feels strongly that it has a valid need to regulate or restrain self-insured ERISA funds in order to promote hospital cost

(Cont'd)

to conclude that a law directly aimed at and intended to proscribe the transactions of employee benefit plans is not pre-empted. *Kilberg* urged:

> "In the state law context, an apparent purpose to regulate, manifested by a reference to employee benefit plans in the text of the law, invariably reflects an actual regulatory purpose. Hence, any law expressly directed toward employee benefit plans 'purports' to regulate the plans within the meaning of section 514.
>
> Congress meant to pre-empt such state laws, however, whether or not they are styled as employee benefit plan regulations. In light of this congressional intent, 'purports' must be construed in its 'normal sense' of 'to have in mind.' " 62 Texas L.R. at 1328, 1329. (Footnotes omitted).[19]

(Cont'd)
containment then it is free to present its case to Congress as the State of Hawaii did in achieving a limited exception to pre-emption for its health care law. *See* ERISA Section 514(b)(5), 29 U.S.C. §1144(b)(5).

19. While the Fund does not agree that a finding of purpose is necessary under Section 514(a), of course, if a state's purpose *is* to regulate employee benefit plans, its action unquestionably "relates to" such plans. As recognized by both the majority and dissenting opinions in *Garcia v. San Antonio Metropolitan Transit Authority*, Nos. 82-1913 and 82-1951 (February 19, 1985), attempts to draw boundaries and identify organizing principles governing broad concepts of federalism are difficult. Congress eliminated this need in Section 514(a) by providing the "relate to" standard of pre-emption. Under it, there is no need to construct rules that would limit the impact of pre-emption. It does not matter whether the relation arises from the purpose of a statute, its impact on employee plans in general, or its application to a particular plan. Any one or all of these examples can give rise to the kind of state action Congress intended to foreclose.

In a footnote to the quoted passage, the article cited with approval the district court opinion in this case.

The conclusion that the state law here does not "relate to" ERISA plans, above all, ignores this Court's unanimous determination in *Shaw* that Congress intended the plain English meaning of the term to control:

> "The breadth of §514(a)'s pre-emptive reach is apparent from that section's language. A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." 103 S.Ct. 2890, 2899-2900 (1983).

The opinion below is directly at odds with the opinions of this Court and should be reviewed.

CONCLUSION

For these reasons, a writ of certiorari should be granted.

Dated: New York, New York
February 22, 1985

Respectfully submitted,

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OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT DECIDED NOVEMBER 26, 1984

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

Cal. No. 1466 — August Term, 1983

(Argued: June 14, 1984 Decided: November 26, 1984)

Docket No. 84-7388

SEBASTIAN REBALDO, as Chairperson of the Board of Trustees of the UNITED OPTICAL WORKERS INSURANCE FUND,

Plaintiff-Appellee,

v.

MARIO CUOMO, Governor of the State of New York; and DAVID AXELROD, Commissioner of Health of the State of New York,

Defendants-Appellants.

Before:

FRIENDLY, VAN GRAAFEILAND and NEWMAN, *Circuit Judges.*

Appeal from a judgment of the United States District Court for the Southern District of New York (Conner, *J.*) declaring N.Y. Pub. Health Law § 2807-a(6)(b) partially invalid and enjoining its enforcement insofar as it affects hospital charges to self-insured employee benefit plans covered by the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461.

Vacated and remanded.

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VAN GRAAFEILAND, *Circuit Judge:*

This is an appeal from a judgment of the United States District Court for the Southern District of New York (Conner, *J.*), which invalidated section 2807-a(6)(b) of New York's Public Health Law to the extent it prohibits a hospital from establishing inpatient charges for self-insured employee benefit plans that are other

than the charges authorized by the section. The provisions of the statute thus invalidated precluded self-insured employee benefit plans such as the United Optical Workers Insurance Fund (United) from negotiating discount rates with hospitals similar to the rates permitted for payors such as Blue Cross, which operates under Article IX-C of New York's Insurance Law.

In holding as it did, the district court adopted appellee's contention that New York's right to set hospital rates chargeable to employee benefit plans was preempted by section 514(a) of the Employee Retirement Income Security Act (ERISA), 28 U.S.C. § 1144(a), which states with certain exceptions that the provisions of ERISA shall supersede State laws insofar as they "relate" to any employment benefit plan. For reasons hereafter stated, we believe that appellee's contention should have been rejected.

During the past several decades, the cost of hospital care has spiraled. *See Greater New York Hospital Association* v. *Blum*, 634 F.2d 668, 669 (2d Cir. 1980); *California Welfare Rights Organization* v. *Richardson*, 348 F. Supp. 491, 496 (N.D. Cal. 1972). In 1983, approximately $8 billion was spent on inpatient hospital care in the State of New York alone. Because approximately two-thirds of this amount was paid by Medicaid and Medicare, both the federal and state governments have sought to develop systems of cost control. However, since Medicaid controls have been more exacting than those of Medicare, administrative attempts to contain hospital costs have been more successful in the former than in the latter.

Medicaid is a joint state and federal program designed to provide medical care to those who otherwise

could not afford it. *Hospital Association of New York, Inc.* v. *Toia*, 577 F.2d 790, 792 (2d Cir. 1978). New York State is one of the voluntary participants in this plan, which it administers in compliance with applicable federal statutes and regulations. In return for such compliance, the federal government has obligated itself to fund up to 60% of the cost of New York's program. 42 U.S.C. § 1396a(a)2.

Almost from the time when New York opted to participate in the Medicaid program, *see* N.Y. Soc. Serv. Law § 363-a, the State has been engaged in a continuing attempt to keep hospital costs within reasonable limits. Prior to 1970, New York reimbursed hospitals on the basis of their actual costs. In 1969, the State decided that this method was too costly and that, effective January 1, 1970, payments would be made in accordance with predetermined rate schedules that reasonably were related to the costs of the services performed. *See Hospital Association of New York State, Inc.* v. *Toia*, *supra*, 577 F.2d at 792 n.1; *National Union of Hospital and Health Care Employees* v. *Carey*, 557 F.2d 278, 279-80 (2d Cir. 1977). Although modified by subsequent legislation, that is the basic manner in which payments are made today.

Medicare, which was established to provide medical care to the elderly, is funded entirely by the federal government. Traditionally, states have played no role in setting Medicare rates or handling Medicare payments. *Mount Sinai Hospital of Greater Miami, Inc.* v. *Weinberger*, 517 F.2d 329, 334 (5th Cir. 1975), *cert. denied*, 425 U.S. 935 (1976). Thus, in contrast to the prospective rate setting method adopted for Medicaid in New York, Medicare continued until 1982 to calculate hospital entitlements on the basis of costs computed at the end of each fiscal year.

As early as 1967, however, Congress realized that "the rigid commitment to a cost basis of reimbursement may provide insufficient incentive for participating providers of services to furnish health care economically and efficiently", and concluded that bases of Medicare reimbursement other than the cost method should be explored experimentally. S. Rep. No. 744, 90th Cong., 1st Sess. *reprinted in* 1967 U.S. Code Cong. & Ad. News 2834, 2905. This realization led to the enactment of Pub. L. No. 90-248, tit. IV, § 402(a), (b), 81 Stat. 930, 931, the precursor of 42 U.S.C. § 1395b-1. In substance, section 402(a),(b) authorized the Secretary of Health, Education and Welfare to develop and engage in experiments under which hospitals would be reimbursed in a manner leading to increased efficiency without any impairment of quality. Section 402(c) of the 1967 statute amended section 1875(b) of the Social Security Act, now 42 U.S.C. § 1395*ll* to provide that the Secretary should submit an annual report to Congress concerning the experiments and demonstration projects authorized by Section 402 (a),(b).

Section 222 of Pub. L. No. 92-603, tit. II, 86 Stat. 1390, enacted in 1972, continued and enlarged upon the Secretary's authority to conduct experiments and demonstration projects. Anticipating that Medicaid and private insurers might participate in these experiments, Congress expressed its intent that "Medicaid and private funds would also be used proportionately when medicaid and private programs participate in the project." H.R. Rep. No. 231, 92d Cong., 2d Sess., *reprinted in* 1972 U.S. Code Cong. & Ad. News 4989, 5068. *See* 42 U.S.C. § 1395b-1 (a)(2).

By the time Congress decided in 1983 to convert Medicare substantially to a system of predetermined

prospective rates, *see* Pub. L. No. 98-21, tit. VI, § 601, 97 Stat. 149 (1983), *codified at* 42 U.S.C. § 1395ww(d), (e),(f), demonstration projects had been established in Maryland, Massachusetts, New Jersey, and New York. Section 603(b) of the 1983 Act, which may be found in the Historical Note following 42 U.S.C. § 1395b-1, provided that "the amendments made by this title shall not affect the authority of the Secretary to develop, carry out, or continue experiments and demonstration projects." In commenting on section 603(b), the report of the House Ways and Means Committee stated:

> Your Committee believes that State cost containment systems have proven effective in reducing the cost of hospital care and that such systems should be encouraged. It is the intent of this provision that the Secretary continue medicare waivers for States which currently have effective demonstration projects and provide an opportunity for new States to develop sound approaches to cost containment. State systems covering all payors have proven effective in reducing health costs and should be encouraged. Such State programs may be useful models for our national system.

H.R. Rep. No. 25, 98th Cong., 1st Sess. 147-48, *reprinted in* 1983 U.S. Code Cong. & Ad. News 219, 366-67.

The Committee's report continues:

> Your Committee bill provides that, upon the request of the State, the Secretary is required to modify the terms of the New York and Massachusetts waivers to eliminate the requirement that the State rate of increase in medicare hospital costs be below the national rate.
>
> . . . .

> Under your Committee's bill and under the current demonstration authority of the Secretary, State systems are required to meet a savings test that is related to medicare.

Id.

The statute invalidated below is part of New York's experiment and demonstration project, a three-year program beginning January 1, 1983. The program was approved by the Secretary on December 21, 1982, pursuant to the authority granted by section 402(a). In pertinent part, this plan provides that the State Commissioner of Health shall establish for each hospital an "inpatient revenue cap", i.e., the maximum amount of inpatient revenue the hospital will be authorized to receive for services during a twelve-month period, N.Y. Pub. Health Law § 2807-a(1), with additional allowances being made for bad debts and charity care, *id.* at (4). Each general hospital is required to establish a charge schedule sufficient to generate the inpatient revenue authorized by the revenue cap, with a proviso that the rate for Article IX-C corporations such as Blue Cross shall be at a discount of from 12% to 15% below that of other non-governmental payors such as United. The statute excepts from this rate differential health maintenance organizations certified under Article 44 of New York's Public Health Law and self-insured and self-administered groups that had hospital rate contracts in effect on May 1, 1982. *Id.* at (6). Because United is not an Article 44 health maintenance organization and had no rate contract in effect on May 1, 1982, it did not fall within the excepted group.

Appellee commenced this action on December 1, 1983. In addition to his claim of preemption under ERISA,

appellee alleged that subsection 6(b) unconstitutionally impaired the obligation of contracts, burdened interstate commerce, denied United equal protection of the law, was void and preempted by the Constitution's supremacy clause, and established anti-competitive price discrimination in violation of the federal antitrust laws. Because the district court held that the rate setting provisions of the statute, as they applied to self-insured employee benefit plans, were preempted by ERISA, the court found it unnecessary to reach appellee's other contentions. The sole issue before this Court, therefore, is whether Congress, in enacting ERISA, intended to preclude the subsequent adoption of experimental and demonstration projects, such as the one at issue herein, to the extent that those plans prescribe hospital rates chargeable to self-insured employee benefit plans.

Appellants' principal argument on appeal is that the setting of rates that hospitals must charge private payors, a group that includes employee benefit plans, does not "relate" to United's plan within the meaning of section 514(a). Appellee's initial response to this argument, albeit a response made almost in passing, is that it was not made in the district court and therefore should not be heard here. Although generally this Court will not consider an issue not passed on below, *Singleton* v. *Wulff*, 428 U.S. 106, 120 (1976), we may, under proper circumstances, make exceptions to this rule, *id.* at 121; *Chico* v. *Schweiker*, 710 F.2d 947, 952 (2d Cir. 1983); *see also Davis* v. *Musler*, 713 F.2d 907, 917 (2d Cir. 1983) (Van Graafeiland, J., concurring) and cases there cited. Because the district court examined the issue of relationship in some detail and because that court's decision has broad legal ramifications and concerns the validity of a State statute, we think this is a case for such an exception.

Moreover, both parties as well as *amici* have fully briefed and argued before this Court whether this New York law "relates to" ERISA plans within the meaning of § 514(a), and the issue is solely one of law the determination of which could not be altered by appellee's producing additional evidence.

Section 514(a) of ERISA, 29 U.S.C. § 1144(a), provides that "the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." In the definitional section, 29 U.S.C. § 1144(c)(2), Congress defined the term "State" for ERISA preemption purposes as follows:

> The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

Thus, a state law must "purport[] to regulate, . . . the terms and conditions of employee benefit plans" to fall within the preemption provision. Appellee contends that this phrase should not be read to impose any special limitation in determining whether the hospital rate regulation in the instant case relates to United.[1] We disagree.

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[1] Appellee relies for this argument on a report issued after the passage of ERISA by the House Committee on Education and Labor that concluded that the phrase "which purports to regulate" modifies "agency or instrumentality" only and does not modify the term "State." H.R. Rep. No. 1785, 94th Cong., 2d Sess. 47-48 (1977). Such reports, although often persuasive, are not binding. We reject this Report's analysis as lacking even persuasive authority. In *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981), the Supreme Court held that the phrase "directly or indirectly" modified both "State" and "agency or instrumentality."

[Footnote continued on following page]

As the district court quite properly recognized, the Supreme Court has given the term "relate" as used in ERISA a broad and liberal construction. *See Shaw* v. *Delta Air Lines, Inc.*, 103 S. Ct. 2890, 2899-900 (1983). However, the preemptive scope of ERISA is neither all-encompassing, *Lane* v. *Goren*, No. 83-6496, slip op. 4263, 4265 (9th Cir. Sept. 27, 1984), nor unlimited, *Savings and Profit Sharing Fund of Sears Employees* v. *Gago*, 717 F.2d 1038, 1040 (7th Cir. 1983). ERISA does not invalidate those State statutes whose effect on pension plans is simply tangential in nature. *Shaw* v. *Delta Air Lines, Inc., supra*, 103 S. Ct. at 2901 n.21; *American Telephone & Telegraph Co.* v. *Merry*, 592 F.2d 118, 121 (2d Cir. 1979). This conclusion follows as a matter of common sense from the fact that ERISA plan members and managers are bound to engage in myriad transactions that Congress never considered when it drafted § 514. A preemption provision designed to prevent state interference with federal control of ERISA plans does not require the creation of a fully insulated legal world that excludes these plans from regulation of any purely local transaction.

The containment of hospital costs is an exercise of a State's police powers, which should not be superseded by federal regulations unless that was the clear intent of Congress. *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S.

[Footnote continued from previous page]

This entirely sensible reading follows naturally the structure of the sentence and its punctuation, and we see no reason to read the immediately preceding clause, "which purports to regulate," any differently. Thus, even without the decision in *Alessi*, we would read the phrase "which purports to regulate, . . . the terms and conditions of employee benefit plans" as modifying the term "State." *Accord, Lane* v. *Goren*, No. 83-6496, slip op. 4263, 4265 (9th Cir. Sept. 27, 1984).

504, 522 (1981); *Massachusetts Nursing Association* v. *Dukakis*, 726 F.2d 41, 44 (1st Cir. 1984); *see Ray* v. *Atlantic Richfield Co.*, 435 U.S. 151, 157 (1978). Accordingly, a State's promulgation of hospital rate schedules should not be found to "relate" to "the terms and conditions of employee benefit plans" unless this conclusion is unavoidable. *See Alessi* v. *Raybestos-Manhattan, Inc.*, *supra*, 451 U.S. at 522.

It is clear that ERISA preempts state laws that require or forbid the provision of a certain kind of benefit. *See, e.g., Stone & Webster Engineering Corp.* v. *Ilsley*, 690 F.2d 323, 329-30 (2d Cir. 1982), *aff'd sub nom. Arcudi* v. *Stone & Webster Engineering Corp.*, 103 S. Ct. 3564 (1983) (state law requires provision of health insurance to former employee receiving workmen's compensation). It is equally clear that ERISA does not preempt every state law that incidentally touches pension plans through its effect on individuals. *See, e.g., American Tel. & Tel. Co.* v. *Merry*, *supra*, 592 F.2d at 123-26 (garnishment of pension benefits to collect alimony and child support). As said in *Shaw* v. *Delta Air Lines, Inc.*, *supra*, 103 S. Ct. at 2901 n.21: "Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." New York's decision to regulate the amounts hospitals can charge falls within this description. Appellee's suggestion that, because this regulation affects pensions plans in their dealings with hospitals by increasing their costs of doing business, it must be found preempted, proves altogether too much. As the court observed in *Lane* v. *Goren*, *supra*, slip op. at 4266:

> That argument does not withstand scrutiny. So too, for example, do State laws and municipal ordinances regulating zoning, health, and safety increase the

operational costs of ERISA trusts, but no one could seriously argue that they are preempted.

See also American Progressive Life & Health Insurance Co. v. *Corcoran*, 715 F.2d 784, 787 (2d Cir. 1983).

The purchase of hospital service is like the purchase of public utility service, or of any other service or commodity whose price is controlled by the State. Insofar as the regulation of hospital rates affects a plan's cost of doing business, it also may be analogized to State labor laws that govern working conditions and labor costs, to rent control laws that determine what employee benefit plans pay or receive for rental property, and even to such minor costs as the Thruway, bridge and tunnel tolls that are charged to plans' officers or employees. In short, if ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress. Where, as here, a State statute of general application does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated.[2]

Moreover, such indirect economic impact as may result from State control over hospital rates does not run counter to ERISA's aim of national uniformity in plan

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[2] The mere fact that section 2807 recognizes differences between groups, including "self-insured groups" like United, and tempers its treatment of these groups to reflect these differences, does not make it any the less a law of general application for preemption analysis. *Cf. New York Tel. Co.* v. *New York State Dept. of Labor*, 440 U.S. 519 (1979) (New York unemployment benefit law that gives special treatment to striking employees is "a law of general application," and thus is not preempted by NLRA).

regulation. *See Shaw* v. *Delta Air Lines, Inc., supra*, 103 S. Ct. at 2890 n.20. There is no valid reason why employee benefit plans cannot be subject to nationally uniform supervision despite dissimilarities in their costs of doing business. Indeed, if statutes such as section 2807-a(6)(b) of New York's Public Health Law are held to be preempted by ERISA, every hospital will be able to set its own rates for ERISA plans, and appellee does not contend that these rates are, or will be, uniform, even as between hospitals in the same locality. Lack of uniformity is not a valid argument for preemption of New York's statute.

The author of this opinion, writing only for himself and not his colleagues, who take no position on the issue, believes that New York's experimental and demonstration project, incorporated in section 2807-a, also is exempted from the preemptive provisions of ERISA by section 514(d) of that Act, which provides that nothing in ERISA shall be construed to "impair . . . any law of the United States . . . or any rule or regulation issued under any such law." 29 U.S.C. § 1144(d).

Medicaid has been described correctly as a "cooperative endeavor", a "cooperative program of shared financial responsibility" between the states and the federal government. *Harris* v. *McRae*, 448 U.S. 297, 308-09 (1980). It is "one of the 'cooperative federalism' welfare programs administered jointly by state and federal governments." *Massachusetts General Hospital* v. *Sargent*, 397 F. Supp. 1056, 1061 (D. Mass. 1975). *See also King* v. *Smith*, 392 U.S. 309, 316 (1968). A federally authorized experimental and demonstration project that incorporates both Medicaid and Medicare certainly is no less a cooperative undertaking.

As already pointed out, Congress authorized the Secretary of Health, Education and Welfare "to develop and engage in experiments and demonstration projects . . . to determine whether the rates of payment . . . for health care services, approved by a State for purposes of the administration of one or more of its laws, when utilized to determine the amount to be paid for services furnished in such State under the health programs established by this chapter, would have the effect of reducing the costs of such programs without adversely affecting the quality of such services." 42 U.S.C. § 1395b-1(a)(1)(C). This statute unambiguously vests the Secretary with authority to engage in such experiments. *Blue Cross Association* v. *Harris*, 622 F.2d 972, 976 (8th Cir. 1980).

> It is a commonplace of statutory construction that a legislative grant of power carries with it the right to use the means and instrumentalities necessary to the beneficial exercise of that power.

Id. at 978. *See also Health Care Service Corp.* v. *Califano*, 601 F.2d 934, 935 (7th Cir. 1979); *California Welfare Rights Organization* v. *Richardson*, *supra*, 348 F. Supp. at 493, 495.

In fact, Congress did more than merely authorize the Secretary to approve New York's demonstration project. In section 603b(1) of the 1983 Act, Congress ratified what the Secretary had done by authorizing the continuation of the established project. The program under review is not simply a New York undertaking; it is a cooperative undertaking of the state and federal governments.

The need for such experimental projects in the continually developing field of public health and assistance

is obvious. "A purpose to determine whether and how improvements can be made in the welfare system is as 'legitimate' or 'appropriate' as anything can be." *Aguayo* v. *Richardson*, 473 F.2d 1090, 1109 (2d Cir. 1973). *See California Welfare Rights Organization* v. *Richardson*, *supra*, 348 F. Supp. at 497. Indeed, the predetermined rate scheduling procedure that New York adopted for Medicaid in 1970 began its existence as an experimental or demonstration project with the approval of the Secretary and later was adopted as a permanent basis for payments. The above outlined history of the numerous congressional enactments authorizing experiments and demonstration projects shows the consistent intent of Congress that such experiments be conducted. When Congress gives authority with one hand, it ordinarily does not take it away with the other.

In attempting to control hospital charges, a State has the choice of setting rates for specific services, a procedure that is both cumbersome and expensive, or of prescribing a "revenue cap" for all services, a procedure that eliminates much of the administrative morass inherent in selective rate setting and gives hospitals some leeway in fixing specific charges. In order for the "revenue cap" concept to operated properly, a plan must provide, as New York's does, for an equitable apportionment of hospital costs among all payors, including the costs of bad debts and charity care. Indeed, the Medicare Act specifically prohibits the shifting of costs between Medicare and non-Medicare payors. 42 U.S.C. § 1395x(v)(1)(A). *See Greater New York Hospital Association* v. *Matthews*, 536 F.2d 494, 499 (2d Cir. 1976); 10 N.Y. Admin. Code, tit. 10, § 86-1.11(b). Were the Secretary prevented from approving experimental reimbursement programs that attempt to regulate all sources of hospital inpatient revenue

and equitably apportion responsibility for bad debt and charity care, the statutory mandate for such experimental programs would be impaired substantially.

In sum, the writer does not believe that Congress intended that ERISA would preempt a project of cooperative federalism, such as we have here, a project that was authorized and ratified by federal statute and is intended in substantial part to conserve federal funds.

The district court's judgment is vacated and the matter is remanded for further proceedings consistent with this opinion.

OPINION AND ORDER OF THE UNITED STATES DISTRICT COURT, SOUTHERN DISTRICT OF NEW YORK DATED MARCH 12, 1984

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

83 Civ. 8707
(WCC)

SEBASTIAN REBALDO, as Chairperson of the Board of Trustees of the UNITED OPTICAL WORKERS INSURANCE FUND,

Plaintiff,

- against -

MARIO CUOMO, Governor of the State of New York, and DAVID AXELROD, Commissioner of Health of the State of New York,

Defendants.

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CONNER, D. J.:

Opinion and Order

Plaintiff Sebastian Rebaldo ("Rebaldo") filed this action on behalf of the United Optical Workers Insurance Fund (the "Fund") in December 1983, seeking declaratory and injunctive relief against implementation of a small portion of the New York Prospective Hospital Reimbursement Method (the "NYPHRM"), New York Public Health Law §2807-a, *et seq.* Among its provisions, the NYPHRM establishes one method of hospital reimbursement for major third-party payors such as Medicare, Medicaid and Blue Cross, and another for all other payors. Rebaldo contends that the subsection in question, §2807-a.6(b), which mandates that rates for charge-paying individuals and groups such as the Fund be set at levels from 12% to 15% higher than rates set for corporations like Blue Cross, is invalid as applied to the Fund. He reasons that because this subsection restricts the right of an employee welfare benefit plan to negotiate with hospitals for reduced rates, it is pre-empted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 *et seq.* (1976 ed. and Supp. V)("ERISA"). Defendants Mario Cuomo, the Governor of the State of New York, and David Axelrod, the Commissioner of Health, are the state officials charged with enforcing the NYPHRM. The matter is now before the Court on cross-motions for summary judgment.[1]

The Fund is a self-insured and self-administered employee welfare benefit plan governed by a board of trustees, of which Rebaldo is the chairman. The Fund receives contributions from employers in various states pursuant to the terms of collective bargaining agreements between the employers and the United Optical Workers, Local 408, and the resulting fund is used to provide hospital and other health and welfare coverage for employees and their dependents. Rebaldo Aff. at ¶1. The parties to this action and *amicus* Blue Cross agree that the Fund is governed by ERISA. Pl's Mem. at 2; Def's Mem. at 2; *Amicus* Mem. at 19.

Prior to 1983 the Fund purchased insurance coverage through Blue Cross. However it suffered financial losses under this arrangement, and in 1982, it retained Donald Rubin ("Rubin") to explore the possibility of self-insuring. Rubin concluded that by self-insuring, the Fund could provide superior benefits at reduced costs. Under his guidance, the Fund terminated its relationship with Blue Cross effective January 1, 1983, and converted to a self-insured and self-administered plan. On behalf of the Fund, Rubin negotiated discount contracts with more than 100 area hospitals; these contracts called for payment rates calculated at 5% above the discount rate paid by Blue Cross. As a result of these negotiated discount arrangements, as well as increased efficiency and lower administrative costs, the Fund estimates that it saved approximately $100,000 in hospitalization costs in 1983 by self-insuring. *Id.* at ¶3.

The New York Legislature enacted the NYPHRM in 1982, following years of proposals and recommendations aimed at remedying a vast array of hospital cost containment problems caused by such conditions as spiraling inflation, inability to cover bad debts and charity care, inadequate efficiency incentives and an inequitable distribution of financial burdens on various categories of payors. *See generally* Ex.A to Sweeney Aff. The ultimate goal of the statute, as characterized by the Director of the Office of Health Systems Management of the New York State Department of Health, is the attaining "financial stability for the hospital industry while at the same time promoting cost containment and overall increased efficiency in hospital operation." Sweeney Aff. at ¶19. The NYPHRM seeks to accomplish this end through a complex and comprehensive "reimbursement methodology" that accounts for and controls all sources of hospital revenue. The central concept is that of an "inpatient revenue cap" established for each hospital, which determines the maximum amount of inpatient revenue the hospital

may receive for services in a given year. Section 2807-a.1; Lovett Aff. at ¶14,; Miller Aff. at ¶4. Once the dollar figure is fixed for each hospital, it is allocated among various categories of payors, in part by the subsection at issue here.

Hospitals receive the great bulk of their revenue for patient care from third-party payors rather than from the personal funds of individual patients. Medicare, Medicaid and Blue Cross account for approximately 80% of payments for hospital care in New York, and the remaining percentage is attributable primarily to private insurance companies, self-insured groups such as the Fund, and individual "self-pay" patients (collectively "charge payors"). Sweeney Aff. at ¶4. In order to implement a comprehensive system to contain hospital costs, and to prevent hospitals from "juggling" reimbursement among payors, making up losses in one area with higher revenues from another, the legislature concluded that it would be necessary to achieve control over the rates paid by each of these groups. Sweeney Aff. at ¶¶20, 25.

The New York State Department of Health already regulated Medicaid reimbursement rates, Sweeney Aff. at ¶5, and similar controls had been exerted over rates charged to Blue Cross, a not-for-profit corporation which is organized pursuant to Article IX-C of the New York Insurance Law, and which is therefore subject to considerable state regulation. Lovett Aff. at ¶3; Sweeney Aff. at ¶9. Prior to the enactment of the NYPHM, however, the federal government had sole responsibility for establishing reimbursement rates for the Medicare program, Sweeney Aff. at ¶7, and the State made no attempt to control self-insured groups that wished to negotiate their own discount rates. In order to bring Medicare reimbursement rates under state control, New York proposed and received from the Office of Research and Demonstration of the federal Health Care Financing

Administration, Ex. A to Lovett Aff., a waiver under which the state was permitted to establish its own method of setting Medicare rates during an experimental three-year period. Sweeney Aff. at ¶¶8, 10.[2] Control over the rates charged to self-insured groups was achieved by the enactment of §2807-a.6.

Section 2807-a.6(a) requires that each hospital establish a charge schedule that will be sufficient to generate the inpatient revenue authorized by the revenue cap. Section 2807-a.6(b) then requires that as of January 1, 1984, each hospital's gross charges shall be set at a level such that the reimbursement rates paid by Blue Cross and other Article IX-C corporations are from 12% to 15% lower than the rates billed to charge-paying patients. In other words, self-insured groups such as the Fund must be charged by each hospital at its full or "gross" rates. Lovett Aff. at ¶16. An express exception not applicable to the Fund's contracts allows for the continuation of negotiated discount systems which were in effect on May 1, 1982.

Plaintiff seeks relief from this Court because the terms of §2807-a.6(b) effectively nullified its negotiated contracts as of January first of this year. He has submitted letters from the administrators of various hospitals with which contracts had been arranged, terminating those agreements "in compliance with section 2807-a(6)(b)." Ex. A to Rebaldo Reply Aff., Ex. A to Rubin Aff. Rebaldo asserts that §2807-a.6(b) "relates to" ERISA plans, and that it therefore falls within the broad scope of ERISA's pre-emption provision. Defendants concede that the subsection relates to ERISA plans, but argue that it escapes pre-emption under two of ERISA's savings clauses, one of which exempts state laws that regulate insurance, and the other which forbids construing ERISA'S preemption provision so as to alter, amend or modify federal law. For the reasons set forth below, I conclude

that §2807-a.6(b) is pre-empted by ERISA, and therefore may not be enforced against funds such as that administered by plaintiff.

Discussion

ERISA is a comprehensive body of federal law designed to promote and protect the interests of employees and their beneficiaries in pension and welfare benefit plans. 29 U.S.C. §1001. An "employee welfare benefit plan" is any plan, fund or program that provides medical, surgical or hospital care or benefits for contingencies such as illness, accident, disability, death or unemployment, 29 U.S.C. §1002(1), and all parties to this action agree that plaintiff's Fund is covered by the terms of this provision. The instant dispute arises under ERISA's pre-emption provision, §514(a), 29 U.S.C. §1144(a), ("§514(a)") and the savings clauses that follow.

With certain exceptions discussed below, §514(a) pre-empts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. The scope of this provision was widely debated after ERISA's enactment, but much of the controversy was put to rest by the Supreme Court in *Shaw v. Delta Air Lines*, ____ U.S. ____, 103 S.Ct. 2890 (1983). The unanimous Court announced in *Shaw:*

> The breadth of §514(a)'s pre-emptive reach is apparent from that section's language. A law "relates to" an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.

Id. at 2899. The Court then cited Black's Law Dictionary for its definition of the term "relate": "To stand in some relation;

to have bearing or concern; to pertain; refer; to bring into association or connection with." *Id.*, n.16. This definition is consistent with ERISA's §514(c)(2), which provides that ERISA pre-empts any state action "which purports to regulate, *directly or indirectly,*" the terms or conditions of covered plans. (emphasis supplied). *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1980) ("It is of no moment that New Jersey intrudes indirectly, through a workers' compensation law, rather than directly, through a statute called "pension regulation". ERISA makes clear that even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern.") The Supreme Court went on to say in *Shaw* that in using the words "relate to" in their broadest sense, Congress rejected the suggestion that §514(a) be interpreted to preempt only state laws dealing with the subject matters specifically covered by ERISA, such as reporting, disclosure and fiduciary responsibility.

The Court recognized that requiring multi-state plans such as Rebaldo's Fund to comply with varying state regulations would have the direct effect of increasing the costs and decreasing the efficiency of fund administration. These increased costs, the Court reasoned, would eventually. result in a reduction of benefits to participants.

> The employer might choose to offer a number of plans, each tailored to the laws of particular states; the inefficiency of such a system presumably would be paid for by lowering benefit levels . . . . ERISA's comprehensive pre-emption of state law was meant to minimize this sort of interference with the administration of employee benefit plans.

103 S.Ct. at 2904, n.25.

ERISA's legislative history was given considerable attention in *Shaw*. The Court extensively quoted the bill's sponsors, who noted as ERISA's crowning achievement its reservation to federal authority of "the sole power to regulate the field of employee benefit plans," and who anticipated that the statute would eliminate any threat of conflicting or inconsistent state and local regulation. *Id.* at 2901, *quoting* Remarks of Representative Dent and Senator Williams, 120 Conf.Rec. 29197 and 29933 (1974). The Court also cited remarks by Senator Javits, who described the "emergence of a comprehensive and pervasive Federal interest" and who recognized that "the interests of uniformity with respect to interstate plans required — but for certain exceptions — the displacement of state action in the field of private employee benefit programs." *Id.* at 2901 n.20, *quoting* 120 Cong. Rec. 29942.

In light of this legislative history, the Supreme Court determined that the specific enumerated exceptions to the pre-emption provision should be narrowly construed. *Id.* at 2902, 2903. ("As we have detailed above, Congress applied the principle of pre-emption "in its broadest sense to foreclose any non-Federal regulation of employee benefit plans," creating only very limited exceptions to pre-emption").

Neither defendants nor *amicus* argues that §2807-a.6(b) does not "relate to" ERISA plans,[3] and such an argument would not prevail. Section 2807-a.6(b) adversely affects the administration of such plans in at least two ways . It is obvious that if the Fund is required to pay the higher reimbursement rates set for charge payors, it will not be able to provide the same breadth of coverage for its beneficiaries. Its other alternative is to return to the previous arrangement of purchasing insurance through Blue Cross, but the Fund asserts that its experience has shown this arrangement to be more expensive than the present system, and that some

reduction in benefits would still be necessary to cover increased costs.

In addition, by imposing a local condition on the administration of covered funds, §2807-a.6(b) runs afoul of ERISA's goal of facilitating the operation of uniform multi-state plans. In order to best conserve assets, the Fund might well find it practical to operate separate plans in different states; it might find that it could provide benefits most efficiently by insuring through Blue Cross in New York and by self-insuring in states without similar restrictions. This would result in higher administrative costs, and as the Supreme Court noted in Shaw, would eventually necessitate a decrease in benefits.

It should be noted, as well, that §2807-a.6(b)'s impact on ERISA plans is not incidental; it is apparent from the express exclusion of discount contracts entered into by "self-insured and self-administered groups" before May 1, 1982 that the legislature considered ERISA plans and fully intended to curtail their ability to negotiate or receive discounts after January 1, 1984. This conclusion is further supported by direct references to "self-insured groups [that] have negotiated payment rates with individual hospitals" in a report by the statutorily-created Council on Health Care Financing, which was charged with devising a plan for financing hospital inpatient care, and also by statements attributed to Edwin Werner, the President of Blue Cross and a member of the Council on Health Care Financing. In a memorandum entitled "Questions and Answers on the Changes in Financing Hospital Care in New York State," Ex.C to Rubin Aff., Werner discussed the impact of the NYPHRM on self-administered funds:

> These funds pay substantially less than other charges-paying patients; in several circumstances,

> their payment rates approximate [Blue Cross'] own. The unfairness of this became obvious to all in the course of the Council on Health Care Financing deliberations. As a result, under the Act, no new arrangements of this sort can be established after May 1, 1982.

Id. at p.7. In discussing the impact of the NYPHRM on Blue Cross, Werner then stated that the "abusive reimbursement practices of self-insured programs will be curtailed." *Id.* at p.8.

I am convinced, based upon the foregoing, that §2807-a.6(b) "pertains to" and "refers to" ERISA funds, and that it has a direct "bearing on" and "connection with" them. This conclusion by no means suggests that the designers of the NYPHRM acted with improper motives toward ERISA funds. To the contrary, defendants and *amicus* have provided the Court with considerable justification for the payment rate differential established between ERISA plans and corporations such as Blue Cross. The wisdom of §2807-a.6(b) is not at issue here, however, and I therefore turn to an examination of whether either of the proffered exceptions to ERISA's broad pre-emption rule apply.

Defendants and *amicus* assert that two of §514(a)'s narrow savings provisions apply to this controversy. The first is subsection (b)(2)(A) of §514, which excepts from pre-emption "any law of any State which regulates insurance." On its face, §2807-a.6(b) certainly does not purport to be an insurance law; it merely regulates the rates at which charge payors compensate hospitals for health care services. As noted above, this group of charge payors includes many individuals who are not covered by insurance at all. Nevertheless, it is apparent from the very existence of the present controversy that this measure has a regulatory effect on

insurance, and I therefore look to the intended meaning of the phrase "law which regulates insurance" in §514(b)(2)(A).[4]

ERISA itself provides no definition of this language, but both parties recognize that §514(b)(2)(A) is a reflection of congressional intent to accommodate the states' primacy in the area of insurance. Pl's Mem. at 6-7; Def's Mem. at 11-12. *See also Wadsworth v. Whaland,* 562 F.2d 70, 78 (1st Cir. 1977); *Eversole v. Metropolitan Life Ins. Co.,* 500 F. Supp. 1162 (C.D.Cal. 1980); *McLaughlin v. Connecticut General Life Ins. Co.,* 565 F. Supp. 434, 443 (N.D.Cal. 1973). That primacy was officially granted by Congress with the enactment of §2(b) of the McCarran Ferguson Act, 15 U.S.C. §§1011-1015 (1976)("the McCarran Act"), and thus it is appropriate to examine the language and background of the McCarran Act in construing ERISA's insurance savings clause.

The McCarran Act was passed in response to the Supreme Court's decision in *United States v. South-Eastern Underwriters Assn.,* 322 U.S. 533 (1944), which held that insurance transactions were subject to federal regulation under the Commerce Clause. Congress was apparently concerned that inroads might be made on the tradition of state insurance regulation, and it therefore sought to "give support to the existing and future state systems for regulating and taxing the business of insurance." *Prudential Ins. Co. v. Benjamin,* 328 U.S. 408, 429 (1946). It accomplished this by enacting §2(b), which provides in relevant part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . .

In *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969), the Supreme Court discussed the meaning of the McCarran Act's "business of insurance" language. The Court stated first that in enacting the measure, Congress intended to assure that states retain the free hand they had previously enjoyed in "regulating the dealings between insurers and policyholders." It is the protection of this relationship, according to the Court, with which laws regulating the "business of insurance" are concerned.

> Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the "business of insurance" does the statute apply. Certainly the fixing of rates is part of this business; . . . *Congress was concerned with the type of state regulation that centers around the contract of insurance,* the transaction which *Paul v. Virginia* held was not "commerce." *The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement — these were the core of the "business of insurance."* Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was — it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."

Id. at 459-60 (emphasis added).

The Supreme Court again addressed the meaning of §2(b)'s "business of insurance" language in *Group Life & Health Insurance Co. a/k/a Blue Shield of Texas v. Royal Drug Co.*, 440 U.S. 205 (1979). *Royal Drug* involved agreements between Blue Shield and certain "participating" pharmacies, under which policyholders would pay only two dollars for each prescription drug purchased, and Blue Shield would then reimburse the pharmacies for the drug acquisition costs. Policyholders who purchased drugs at non-participating pharmacies would pay full price, and could seek partial reimbursement from Blue Shield. The only issue before the Court was whether the establishment of these pharmacy agreements between Blue Shield and the participating pharmacies constituted the "business of insurance" which, under the McCarran Act, could only be regulated by the state.

In concluding that entry into these agreements did nor constitute the "business of insurance," the Court first discussed the significance of risk-spreading as an indispensable characteristic of insurance. Rejecting Blue Shield's suggestion that the agreements did involve undewriting of risks, the Court said:

> The benefit promised to Blue Shield policy holders is that their premiums will cover the cost of prescription drugs except for a $2 charge for each prescription. So long as that promise is kept, policyholders are basically unconcerned with arrangements made between Blue Shield and participating pharmacies.
>
> The Pharmacy Agreements thus do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods

> and services by Blue Shield. By agreeing with pharmacies on the maximum prices it will pay for drugs, Blue Shield effectively reduces the total amount it must pay to its policyholders. The Agreements thus enable Blue Shield to minimize costs and maximize profits. Such cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the "business of insurance."

Id. at 214-15 (footnotes omitted).

The Court went on to emphasize that the pharmacy agreements were simply contractual arrangements between Blue Shield and the pharmacies for the sale and distribution of goods and services other than insurance, and that they did not implicate the relationship between insurer and insured, which was at the heart of §2(b) of the McCarran Act. For these reasons, the Court concluded that the agreements were not "the business of insurance" within the meaning of that Act. *Id.* at 230.

In the instant case, the Fund negotiated with third parties for the delivery of health care services at a discount price. The contracts were designed to reduce the Fund's costs and preserve its assets, but they had no direct impact upon the relationship between the Fund and its beneficiaries. In short, within the meaning of the McCarran Act, the Fund was not engaging in the "business of insurance" when it executed the contracts affected by the implementation of §2807-a.6(b).

Of course, §514(b)(2)(A) of ERISA does not contain the "business of insurance" language found in the McCarran Act;

it refers simply to "any law . . . which regulates insurance" Nevertheless, several courts have concluded, correctly I believe, that the two provisions promote the same policy and should therefore be construed consistently. *See Wadsworth v. Whaland*, 562 F.2d 70, 78 (1st Cir. 1977) ("[T]he national policy of primacy in the regulation of insurance announced by Congress in the McCarran-Ferguson Act . . . is twice reaffirmed by ERISA in §514: first with the saving clause and again with subsection (d)"); *McLaughlin v. Connecticut General Life Insurance Co.*, 565 F. Supp. 434, 445 (N.D. Cal. 1983); *Eversole v. Metropolitan Life Insurance Co.*, 500 F. Supp. 1162, 1168 (C.D. Cal. 1980) ("The two statutes are *in pari materia* and should therefore be construed consistently"). In light of the Supreme Court's conclusion that the specific exceptions to ERISA's general pre-emption rule are to be construed narrowly, I see no purpose in interpreting the reference to insurance regulation in §514(b)(2)(A) more broadly than the corresponding reference in the McCarran Act. It follows, therefore, that §2807-a.6(b) of the New York Public Health Law is not saved from pre-emption under ERISA's insurance savings clause.

Blue Cross has proposed an alternative method of saving §2807-a.6(b) from pre-emption, inviting the Court's attention to §514(d) of ERISA. This subsection states:

> Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair or supersede any law of the United States or any rule or regulation issued under any such law.
>
> *Amicus* contends that if this Court were to construe ERISA to pre-empt §2807-a.6(b), the federal government would be impaired in its ability to

discharge its responsibilities under the Medicare program, Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq*. The theory, although creative, is also flawed.

Underlying Blue Cross's argument is a concern for the continued viability of the federal government's Medicare waiver, which was granted under a section of the Social Security Act designed to encourage experimentation with Medicare reimbursement at the state level, and which was, in fact, a condition precedent to implementation of the NYPHRM. The source of this concern is a provision, codified as a note to §2807,which provides that:

> if any payor reduces its rate of payment below that which is developed in accordance with the provisions of section twenty-eight hundred seven-a of the public health law, . . ., the provisions of this act shall have no force and effect and the provisions of the public health law as they existed immediately prior to the enactment of this act shall be restored and deemed to be in full force and effect.

1982 N.Y. Laws, ch. 536, §10(a). Blue Cross argues that even though plaintiff has asked the Court to enjoin application of §2807-a.6(b) only insofar as it applies to ERISA funds, the language quoted above forecloses any possibility of such limited relief — in other words, if §2807-a.6(b) is pre-empted, the whole scheme will be invalidated.

According to Blue Cross, when the Secretary of Health and Human Services granted the waiver, it thereby "adopted" the NYPHRM scheme for the federal Medicare program, *Amicus* contends this is precisely the sort of operational experiment Congress clearly sought to enable by enacting §514(d). *Amicus* letter of February 17, 1984, ¶6.

Plaintiff responds that NYPHRM's non-severability clause, §10(a) of L.1982, ch. 536, was intended only to assure the continuing participation of the state's three major payors, Medicare, Medicaid and Blue Cross, in the overall scheme, and does not apply to ERISA funds. Plaintiff suggests that another general severability clause, found at §2813 of the Public Health Law, operates to save §2807-a from pre-emption except to the extent that it is held unenforceable against ERISA funds, Pl's Reply Mem. at 17, and that pre-emption therefore poses no threat to the continued viability of the Medicare waiver.

Defendants and *amicus* have emphasized repeatedly the comprehensiveness of the NYPHRM, and the importance of incorporating into the reimbursement scheme all sources of hospital revenue. These considerations militate against adoption of plaintiff's construction of §10(a). On the other hand, plaintiff has correctly recognized that a literal construction of the language would lead to the absurd result that "a single uninsured patient who settled his hospital account for less than the charge payer rate would invalidate the statute." Pl's Reply Mem. at p.17 n.6. Given the importance of the objectives served by the NYPHRM, the extensive time and effort expended in designing and implementing the complex statutory scheme, and the obvious need for some degree of flexibility in its administration,[3] I believe that had the New York Legislature been presented with the ambiguity raised here, it would have clarified §10(a) or made some other

provision to avoid the drastic result predicted by *amicus*. My confidence is bolstered by the fact that the suggestion that pre-emption of §2807-a.6(b) would invalidate the NYPHRM in its entirety was raised not by the Office of the New York State Attorney General, but only by *amicus* Blue Cross. It would appear, then, that the defendants do not share Blue Cross's concern for the future of the NYPHRM.

Fortunately, it is not necessary for me to second-guess the New York Legislature in order to resolve the legal issue at hand. Even assuming the legislature fully intended that pre-emption of any one provision would result in the defeat of its entire statutory scheme and the nullification of the special Medicare waiver, I have concluded that such a disposition would not alter, modify or impair "any law of the United States or any rule or regulation issued under any such law" within the meaning of §514(d) of ERISA.

Medicare is a comprehensive health insurance program for elderly and disabled persons. Medicare Hospital Insurance (Part A) covers medically necessary inpatient care in a hospital, and thereafter in a skilled nursing facility, while Medicare Medical Insurance (Part B) primarily covers medically necessary outpatient services and supplies. The Secretary of Health and Human Services (the "Secretary") is granted authority under 42 U.S.C. §1302 to "make and publish such rules and regulations . . . as may be necessary to the efficient administration" of the Medicare program, and she has exercised that authority by publishing regulations governing reimbursement for services rendered to persons covered under Medicare Part A. *See* 42 C.F.R. §405 (1982). These regulations set forth the retrospective reimbursement procedure from which the New York State Department of Health sought relief in order to implement the NYPHRM.

The Secretary is authorized under 42 U.S.C. §1395b-1(a)(1)(c) to engage in experiments and demonstration projects designed to determine whether the rates of payment or reimbursement approved by a state for purposes of administering its own laws would reduce the cost of Medicare coverage without adversely affecting the quality of services. Section 1395b-1(b) provides that in the case of any experiment or demonstration project entered into under subsection (a), the Secretary may waive compliance with applicable reimbursement requirements. Under this authority, the Federal Health Care Finance Administration's Office of Research and Demonstrations issued a letter to the Commissioner of the New York State Department of Health on December 14, 1982, granting such a waiver. Ex.A to Lovett Aff.

Blue Cross has not suggested that the predicted nullification of the NYPHRM by pre-emption of §2807-a.6(b) would impair in any way the continued ability of the Secretary to grant waivers under 42 U.S.C. §1395b-1(b). It argues, instead, that the particular waiver granted for purposes of implementing the NYPHRM would be jeopardized, and that this waiver amounts to a "rule or regulation" which cannot be impaired under §514(d).[6]

> By formal action denominated "Waiver" (42 U.S.C. §1395b-1(b)(1976), throughout New York the Secretary has substituted for "rules and regulations" set forth in 42 C.F.R. those regulations for reimbursement under Medicare Part A prescribed by NYPHRM. . . . In effect, then, the Secretary's "Waiver" action has constituted adoption of new "regulations" to govern Medicare Part A reimbursement for New York.

Amicus letter of February 17, 1984, ¶3. For the several reasons set forth below, I cannot agree.

Section 514(d) of ERISA refers to "any rule or regulation issued under any federal law," but nowhere in the statute is that phrase defined. The Medicare waiver itself is surely not a federal regulation; it merely relieves Medicare providers in New York of their obligation to comply with federal regulations. A rule, in its broadest sense, may be "an agency statement of general or particular applicability," Administrative Procedure Act, 5 U.S.C. §551(4), but rulemaking by an agency "characteristically involves the promulgation of concrete proposals, declaring generally applicable policies binding upon the affected public generally. *PBW Stock Exchange Inc. v. SEC,* 485 F.2d 718, 732 (3d Cir. 1973), *cert. denied,* 416 U.S. 969 (1974). *See, e.g., Hospital Association of New York State v. Toia,* 438 F. Supp. 866, 872 (S.D.N.Y. 1977) (In approving New York State Medicaid plan, HEW acted in "neither an adjudicatory, nor a rule making capacity"); *Vandemark v. Housing Authority of the City of New York,* 663 F.2d 436, 440 (3d Cir. 1981). In determining whether the waiver is within this definition, I am of course cognizant of the Supreme Court's mandate that exceptions to ERISA's general pre-emption provision be narrowly construed. In light of that mandate, it is inconceivable that Congress intended to permit a state to circumvent ERISA's requirements merely by persuading a federal bureaucrat to act favorably upon a proposal that embodies otherwise impermissible measures, and then protecting this transgression by means of a non-severability clause.

The Medicare waiver was apparently obtained upon an *ex parte* application. There was no publication or opportunity for opponents to be heard, and the record is devoid of any indication that federal agency officials even considered the potential impact of the proposed plan on ERISA funds before approving the waiver. Under all of these circumstances, I cannot accept *amicus'* argument that the waiver effectively converted state law into federal law.

See, e.g., Vandemark, 663 F.2d at 441 ("[Local housing authority's] indebtedness policy was part of a policy submitted by the [authority] as part of its administrative plan which was approved by HUD . . . . However, the approval of the [authority's] policy did not establish a general policy which would bind all housing authorities and tenants . . . . The indebtedness policy is not, therefore, a policy of HUD but is rather a policy of the local housing authority").

I am also convinced that Congress would not approve the sort of patchwork pattern of laws affecting ERISA funds that would inevitably result if each state were to obtain a Medicare waiver and adopt its own variation of the NYPHRM. Multi-state ERISA funds such as that administered by plaintiff would then be placed in the awkward position of having to comply with the several states' differing provisions. Obviously, when viewed in light of the legislative history of ERISA's pre-emption provision with its heavy emphasis on interstate uniformity, such a result cannot be justified.[7]

As set forth above, I am not persuaded that Blue Cross is correct in its position that pre-emption of §2807-a.6(b) would result in the invalidation of the NYPHRM. If Blue Cross is correct, the result would, indeed, be unfortunate; I have reviewed the voluminous submissions detailing the need for reforms in New York's hospital reimbursement scheme, and I have been most impressed with the efforts devoted over many years to establishing this innovative and comprehensive alan. Nonetheless, this Court is bound to comply with express congressional intent to displace all state action in the field of private employee benefit programs and §2807-a.6(b) trenches upon that protected area. The Supreme Court recognized in *Shaw* that application of ERISA's pre-emption rules might well cause problems in the administration of New

York's fair employment laws. The Court concluded, however, that "those problems are the result of congressional choice and should be addressed by congressional action." 103 S.Ct. at 2904-5. The state has a similar remedy here.

For all of the reasons set forth above, I conclude that summary judgment for plaintiff is appropriate. Section 2807-a.6(b) of New York's Public Health Law is pre-empted insofar as it relates to ERISA funds, and enforcement against such funds is hereby enjoined.[8]

Plaintiff is instructed to submit a proposed judgment within five days of the date of this Opinion and Order, on five days' notice.

SO ORDERED.

s/ William C. Conner
United States District Judge

Dated: New York, New York
March 12, 1984

FOOTNOTES

1. Plaintiff's complaint asserts several causes of action in addition to the ERISA pre-emption claim. It alleges that §2807-a.6(b): (1) is pre empted by the Sherman Act, 15 U.S.C. §1 *et seq.;* (2) violates the Commerce, Contracts, and Supremacy Clauses of the United States Constitution; and (3) violates the Equal Protection Clause of the 14th Amendment. In hopes of obtaining a prompt disposition, plaintiff filed along with his complaint an order to show cause for entry of a preliminary injunction.

The Court set up a briefing schedule and granted permission for Blue Cross and Blue Shield of Greater New York to file an *amicus curiae* brief in opposition to a preliminary injunction. The parties and *amicus* thereafter addressed the likelihood of plaintiff's prevailing on the merits of his claim, as well as the irreparability of harm.

The Court made a preliminary review of the various submissions and concluded, at least with respect to the ERISA claim, that there were no factual issues to be resolved at a trial on the merits and a prompt resolution on the merits would be possible. A conference was convened on January 25, 1984, at which the parties and *amicus* were asked whether there would be any objection to the Court's treating the submissions as cross-motions for summary judgment on the ERISA claim and delaying resolution of the other claims. All interested parties indicated that this would be an appropriate manner in which to proceed because there were no disputed issues of material fact, and that they had no additional materials to submit.

2. The rate-setting procedure employed by the federal government is "retrospective." This means that "hospitals were issued rates estimated as adequate to cover their current costs for caring for Medicare patients and these rates were then subsequently retroactively adjusted to reflect the facilities' actual expenses." Sweeney Aff. at ¶7. According to Raymond Sweeney, the Director of the Office of Health Systems Management of the New York State Department of Health, this retrospective system was criticized because it provided no incentive to contain costs or increase efficiency. *Id.*

Under the "prospective" method adopted in New York, reimbursement rates are generally computed on the basis of actual expenditures in a previous "base year," and then adjusted for inflation. According to Sweeney, this system provides an incentive for hospitals to increase efficiency because they retain excess revenue generated by keeping actual per diem expenses below their per diem reimbursement rates. *Id.* at ¶6.

3. Defendants and *amicus* argue only that §2807-a.6(b) is saved from pre-emption by express exceptions to the broad rule of §514(a). Defendants assert that the "state is functioning here in an area [insurance regulation] in which it has primacy . . . . Accordingly, plaintiff's ERISA preemption claims must fail." Def's Mem. at p.11. Blue Cross states: "It is upon each of these express requirements — that ERISA not be construed to impair the discharge of other federal authority and that ERISA's pre-emption shall not apply to state laws regulating insurance — that plaintiff's ERISA claims founder. Mem. of *Amicus* at p.20.

4. This subsection is followed by a qualifying "deemer clause," §514(b)(2)(B), which provides that an employee benefit plan shall not "be deemed to be an insurance company or other

insurer . . . or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, . . . or investment companies." Various courts and commentators have struggled to delineate the scope and explain the interaction of these subsections, particularly where legislation regulating aspects of insurance traditionally governed by the states has had an indirect or incidental impact on ERISA-covered plans. Their conclusions have not been consistent, and efforts to reconcile the varying interpretations have created still greater confusion. *See generally* Michigan United Food & Commercial Workers Union v. Baerwaldt, 572 F. Supp. 943 (E.D.Mich. 1983); Eversole v. Metropolitan Life Ins. Co., 500 F. Supp. 1162 (C.D.Cal. 1980); Manno, *ERISA Pre-emption and the McCarran-Ferguson Act: The Need For Congressional Action,* 52 Temple L.W. 51 (1979); Brummond, *Federal Pre-emption of State Insurance Regulation under ERISA,* 62 Iowa L.R. 57 (1976); *see also* American Progressive Life & Health Ins. Co. of New York v. Corcoran, 715 F.2d 184 (2d Cir. 1983). *But see* Attorney General v. Traveler's Insurance Co., 432 N.E. 433 2d 1223 (Mass. 1982), *vacated and remanded sub nom.,* Metropolitan Life Ins. Co. v. Massachusetts, ____ U.S. ____, 103 S.Ct. 3563 (1983). Fortunately, the present controversy does not present so delicate an issue. I conclude that §2807-a.6(b) does not "regulate insurance" within the meaning of §514(b)(2)(A), and therefore I find it unnecessary to join the fray.

5. The statute itself provides for some flexibility. Section 2807.10 provides:

> Notwithstanding the provisions of this article, the commissioner may waive, subject to the approval of the state director of the budget, the requirements

> of any provisions of this section *or section twenty-eight hundred seven-a* to permit the development and/or continuation of limited pilot reimbursement programs to provide additional knowledge and experience in different types of reimbursement mechanisms for general hospitals. (emphasis supplied).

6. *Amicus'* reliance on *Shaw* is misplaced because *Shaw* dealt with the impairment of Title VII of the Civil Rights Act of 1964, 42 U.S.C. §2000e *et seq.*, which is quite obviously a "law of the United States."

7. Indeed, the Court has been informed that prior to the enactment of the NYPHRM, the state received Medicare waivers from the federal government in order to establish two experimental reimbursement projects which operated at a regional level. Anderman Aff. at ¶5. It is conceivable, then, that ERISA plans would be subject to conflicting requirements *within* a given state.

8. Because §2807-a.6(b) is pre-empted by ERISA, I need not reach the other arguments raised by plaintiff.

ORDER OF JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK DATED MARCH 30, 1984

UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF NEW YORK

83 Civ. 8707
(WCC)

SEBASTIAN REBALDO, as Chairperson of the Board of Trustees of the UNITED OPTICAL WORKERS INSURANCE FUND,

Plaintiff,

-against-

MARIO CUOMO, GOVERNOR OF THE STATE OF NEW YORK; and DAVID AXELROD, COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK,

Defendants.

This cause having come to be submitted before Hon. William C. Conner, United States District Judge, on plaintiff's motion for a preliminary injunction against New York Public Health Law §2807-a(6)(b) on the grounds that the state statute, in part, is pre-empted by §514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1144(a), in part, conflicts with 15 U.S.C. §§1, 2, 13, 42 U.S.C. §1395ww, in part, violates the supremacy, commerce and contracts clauses of the United States Constitution and, in part, denies plaintiff equal protection of the laws under the Fourteenth Amendment to the United States Constitution; and the parties and the *amicus curiae*, Blue Cross

and Blue Shield of Greater New York, having consented to treating the motion for a preliminary injunction and the opposition thereto as cross-motions for summary judgment on plaintiff's claim that Public Health Law §2807-a(6)(b), in part, is pre-empted by ERISA, 29 U.S.C. 1144(a); and the court having considered the pleading, affidavits, exhibits, memoranda and letter-memoranda and having issues an opinion and order dated March 12, 1984; it is

ORDERED, ADJUDGED AND DECREED:

1. Plaintiff's motion for summary judgment is granted to the extent set forth in paragraphs 2 and 3 hereof, and defendants' motion for summary judgment is denied;

2. Public Health Law §2807-a(6)(b), in part, is declared pre-empted by ERISA, 29 U.S.C. §1144(a), and the state statute is invalid to the extent it prohibits a hospital from establishing inpatient charges for self-insured employee benefit plans covered by ERISA which are other than those authorized by Public Health Law §2807-a(6);

3. Defendants, their successors, officers and employees are enjoined from enforcing Public Health Law §2807-a(6)(b) to the extent the state statute prohibits a hospital from establishing inpatient charges for self-insured employee benefit plans covered by ERISA which are other than those authorized by Public Health Law §2807-a(6); . . .

Dated: New York, New York
March 30, 1984

Order

s/ William C. Conner
United States District Judge

Judgment Entered 3/30/84
s/ Raymond F. Burghardt
Clerk

ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT DATED NOVEMBER 26, 1984

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

84-7388

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York on the twenty-six day of November one thousand nine hundred and eighty-four.

Present:

HON. HENRY J. FRIENDLY

HON. ELLSWORTH A. VAN GRAAFEILAND

HON. JON. O. NEWMAN
Circuit Judges,

SEBASTIAN REBALDO, as Chairperson of the Board of Trustees of the UNITED OPTICAL WORKERS INSURANCE FUND,

Plaintiff-Appellee,

v.

MARIO CUOMO, Governor of the State of New York; and DAVID AXELROD, Commissioner of Health of the State of New York,

Defendants-Appellants.

Order

Appeal from the United States District Court for the Southern District of New York.

This cause came on to be heard on the transcript of record from the United States District Court for the Southern District of New York and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now hereby ordered, adjudged and decreed that the judgment of said District Court be and it hereby is vacated and the action be and it hereby is remanded to the said district court for further proceedings in accordance with the opinion of this court.

Elaine B. Goldsmith,
Clerk

s/ Edward J. Guardaro,
Deputy Clerk

A True Copy
Raymond F. Burghardt, Clerk

s/ J. Caffey
Deputy Clerk

RELEVANT STATUTES

State Statute

New York Public Health Law §2807-a(6) states in part:

Hospital charge schedules. Effective for the year beginning January first, nineteen hundred eighty four and thereafter, each general hospital shall establish a charge schedule for available and authorized services in accordance with a gross charge determination formula provided by the commissioner which shall:

(a) Establish gross charges sufficient to generate the inpatient revenue authorized by the revenue cap; and

(b) Establish gross charges such that (i) the payment rate to be made on behalf of subscribers of corporations organized and operating in accordance with article nine-C of the insurance laws, adjusted for uncovered services, shall be at a specified discount from the gross charge rate billed to or on behalf of charge paying patients; (ii) permit the continuation of negotiated payment rate determination systems between self-insured and self-administered groups and hospitals which were in effect on May first, nineteen hundred eighty-two; and (iii) for general hospitals subject to the provisions of paragraph (a) or (b) of subdivision twelve of this section [providing for article nine-c corporations and health maintenance organizations], the costs (including all allowances specified in subdivision four of this section) or services provided to charge paying patients shall be at a specified discount from the gross charge rate billed to or on behalf of charge paying patients.

During the period of January first, nineteen hundred eighty-four through December thirty-first nineteenth hundred ninety-five, the discount referred to in subparagraphs (i) and (iii) of paragraph

(b) of this subdivision shall not exceed twelve percent for those hospitals which had a discount of less than twelve percent during the previous year, shall be no greater than the discount in effect during the previous year for those hospitals whose previous year's discount was between twelve and fifteen percent and shall not exceed fifteen percent for all others. Self-insured and self-administered negotiated systems as described in subparagraph (ii) of paragraph (b) of this subdivision may remain in effect for the period commencing January first, nineteen hundred eighty-three and ending on December thirty-first, nineteen hundred eighty five and shall be incorporated in the formula methodology provided by the commissioner.

* * *

Federal Statute

§1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

* * *

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person

from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003 (a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company. or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Relevant Statutes

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(c) of this title) or any rule or regulation issued under any such law.

(Pub. L. 93-406, Title I, §514, Sept. 2, 1974, 88 Stat. 897; Pub. L. 97-473, Title III, §§ 301(a), 302(b), Jan. 14, 1983, I 96 Stat. 2611, 2613.)